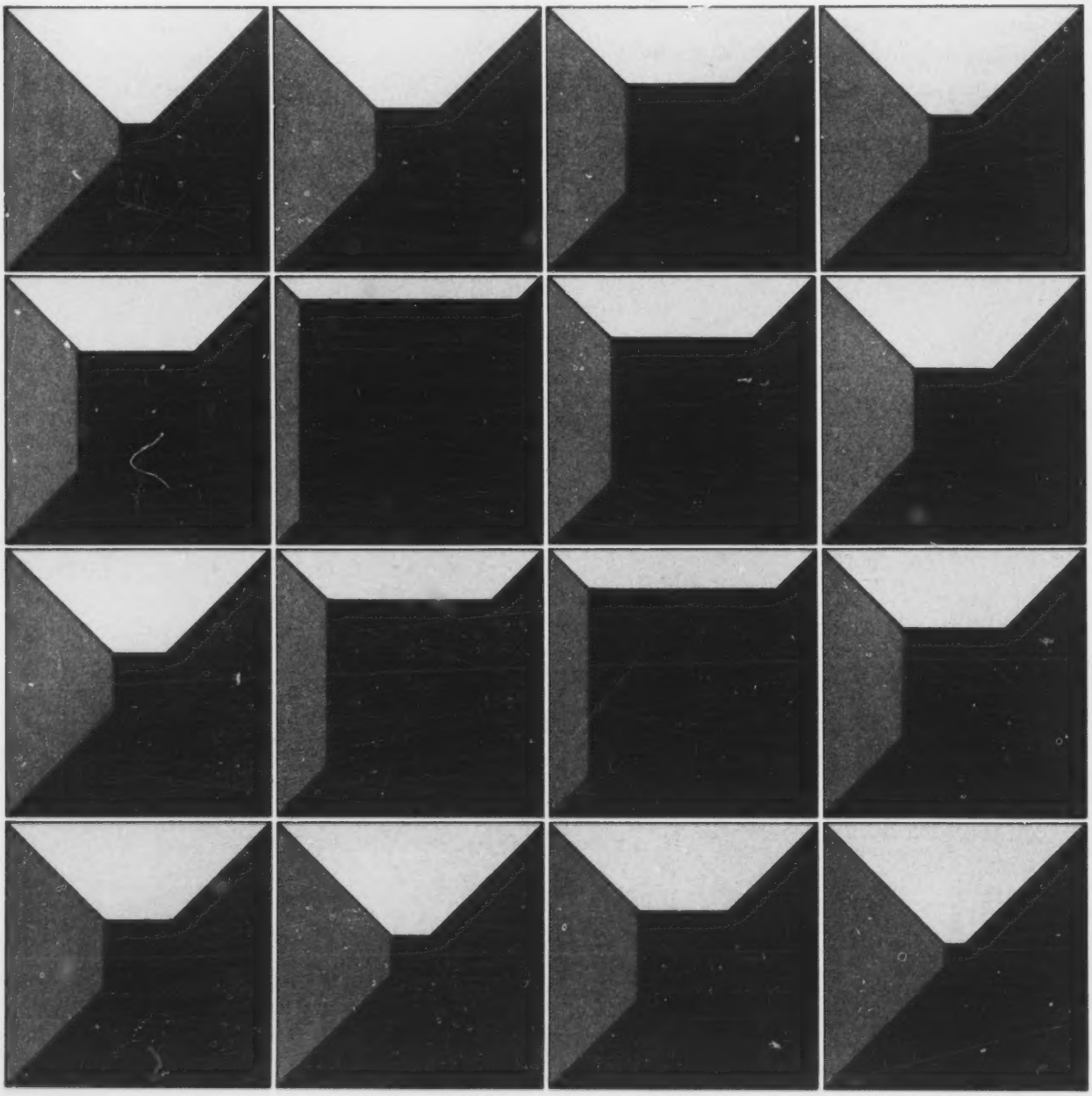
A CBO Study

Options for Change in Military Medical Care

March 1984

Congress of the United States
Congressional Budget Office



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PREFACE

The Department of Defense supplies medical benefits to almost 10 million eligible beneficiaries, at an annual cost exceeding $5 billion. In recent years, several studies have proposed changes in military medical care. This report, prepared at the request of the Subcommittee on Military Personnel and Compensation of the House Committee on Armed Services, discusses options for changing the military medical program that could reduce costs and possibly improve aspects of service. In keeping with the mandate of the Congressional Budget Office (CBO) to provide objective and impartial analysis, this study offers no recommendations.

This report was prepared by Joel Slackman of the CBO's National Security and International Affairs Division, under the general supervision of Robert F. Hale. The report greatly benefited from the assistance and comments of Julie Carr and John D. Mayer, Jr., of the National Security and International Affairs Division, and of Paul Ginsburg and Dorothy Amey of CBO's Human Resources and Community Development Division. The author gratefully acknowledges the cooperation of the Office of the Assistant Secretary of Defense for Health Affairs and the staff of Vector Research, Inc., in providing data. Also of great help were reviews by Dr. Susan Hosek of the RAND Corporation and Christopher Gamble of the Office of Management and Budget. (Outside assistance implies no responsibility for the final product, which rests solely with CBO.) The report was edited by Francis Pierce, assisted by Nancy H. Brooks.

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SUMMARY

To supply medical services for uniformed military personnel, retirees, and their dependents, the Department of Defense (DoD) spends over $4 billion a year operating several hundred military hospitals and clinics. When necessary, it supplements military facilities with civilian medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), costing another $1 billion a year.

Concern about large and growing spending on military medical care has led to calls for reforming the military's system of health care. Two approaches in particular could save at least $2 billion over the next five fiscal years and possibly improve aspects of health care services: charging outpatients when they visit military physicians, and collecting from private insurance companies when their military policyholders use military hospitals and clinics. Two other broader approaches, budgeting with Medicare's system of prospective reimbursement and "closing" medical enrollments--that is, restricting the sources of medical care--also hold potential for saving money and improving service, though they probably would be more difficult to carry out.

CHARGING OUTPATIENTS

A majority of the patients visiting military physicians are not on active duty. They include dependents of people who are on active duty, people retired from the military and their dependents, and survivors of deceased military personnel. Because outpatient care in military medical facilities now is free, these beneficiaries may be overusing medical services. Their heavy use increases waiting lines, which in turn forces many beneficiaries to get more expensive civilian care under CHAMPUS. Charging outpatients could mitigate this problem, while also raising revenue.

Revenue from the Fees

DoD could raise between $500 million and $840 million over the next five years (in current dollars) by charging nonactive-duty beneficiaries modest fees for their outpatient visits. To collect these fees, DoD would have to spend between $15 million and $25 million a year. (DoD could modify one or more of the automated information systems it now uses.) Net savings would depend on how the fees were designed:

- Charging everyone $5 a visit--as an earlier governmental study recommended--could raise $500 million in revenue, less $90 million in administrative costs, over the next five years;

- Charging everyone $10 a visit, but limiting a person's expenses in a single year to $100--as recommended by some in the Congress--could raise $845 million in revenue, less $120 million in administrative costs (higher than above because the limit on expenses could complicate record-keeping);

- Charging dependents of active-duty personnel $5 a visit and everyone else $10--a differential consistent with current priorities for treatment--could raise $680 million in revenue, less $90 million in administrative costs; and

- Charging enlisted dependents and retirees $5 a visit with a $100 limit on their yearly expenses, and officer dependents and retirees $10 a visit with a $200 limit--thus basing the fee on ability to pay--could raise $585 million in revenue, less $120 million in administrative costs.

Additional Savings from Reduced Waiting Lines

In addition to raising revenue, outpatient fees could reduce the overcrowding that results in long waiting lines. The experience of civilian health plans suggests that even the smallest proposed fee--a uniform $5 charge--could reduce present use of the military's outpatient services by about 14 percent. This reduction could accommodate many CHAMPUS patients and still translate into shorter waiting times for the military's outpatients. Many CHAMPUS users would welcome the opportunity to visit military physicians instead, because even with fees military care would cost less than does civilian care.

Less recourse to CHAMPUS would save DoD another $435 million to $480 million over the next five years. This is because DoD can supply additional outpatient services at less cost through military facilities than through CHAMPUS.

Effects on Military Families

Outpatient fees would cause many military families to spend more out of pocket. This could be detrimental to the retention of military personnel. It could also discourage people from seeking essential health care. But both effects should prove to be modest.

Small Increases in Average Family Spending. Each of the four options would bring about modest increases in average out-of-pocket costs for military families, but never more than about $90 a year (see the Summary Table). Even with the outpatient charges, military families would still spend much less on the average for medical care than do typical civilian families. Military families headed by an active-duty person now spend almost $1,600 a year less than typical urban civilian families with comparable incomes; military families headed by retirees spend almost $1,000 a year less.

Large Increases for a Few Families. A few families who make heavy use of outpatient services could spend over $300 more a year on medical care. But they would make up no more than 3 percent of all families under any of the options (see Summary Table).

A $100 limit on expenses would ensure that no single person bore very high expenses. But compared with options that lack limits, options limiting expenses would not greatly reduce the percentage of families with very high expenses. This is because many of the families making heavy use of outpatient services have no single member who visits 10 or 20 or more times a year, and so are not helped by the limit of $100 per person.

No Serious Manning Problems. Because these options would increase out-of-pocket expenses for most military families only modestly, they should not greatly affect the willingness of people to stay in the military. With or without outpatient fees, the size of the crucial career force (members who have served for over four years) should continue to expand in the next few years.

Modest Effects on Health. Experience from civilian health plans also suggests that charging an outpatient fee would reduce visits without harming most peoples' health. Exceptions might include some of the poorer beneficiaries who already have potential health problems--mainly among the families of junior enlistees and families headed by survivors of retired enlistees--who might forgo needed care, particularly if individual expenses were not limited. DoD could protect these people by screening for obvious medical problems like hypertension that might otherwise go untreated. Alternatively, DoD might waive charges for the few poorest military families.

Variations in Outpatient Charges. When equal for all, outpatient charges favor neither enlisted personnel nor officers. If the Congress wanted better-off military families to bear greater costs, it could charge officers more, as does the fourth option. Even then, families headed by active-duty officers would only have to spend an average of $90 more a year; families headed by active-duty enlistees, $40.

SUMMARY TABLE. ESTIMATED INCREASES IN AVERAGE YEARLY SPENDING ON MEDICAL CARE BY MILITARY FAMILIES, AND PERCENTAGES OF FAMILIES SPENDING MORE THAN $300, UNDER ALTERNATIVE OUTPATIENT CHARGES (In current dollars)

	Active-Duty		Retired		Budget Savings 1985-1989
	Enlisted	Officer	Enlisted	Officer	
Option I. Charge all $5					$845 million
Average	$45	$50	$30	$20	
Percent over $300	1.0	1.5	0.5	0.0	
Option II. Charge all $10, with $100 limit					$1,185 million
Average	$75	$80	$45	$35	
Percent over $300	2.0	1.5	1.0	0.5	
Option III. Charge active-duty $5, retired $10					$1,070 million
Average	$45	$50	$60	$45	
Percent over $300	1.0	1.5	3.0	1.0	
Option IV. Charge enlisted $5, with $100 limit; officers $10, with $200 limit					$910 million
Average	$40	$90	$25	$40	
Percent over $300	0.5	1.5	0.5	0.5	

Uniform charges would favor families headed by retirees over those headed by active-duty personnel, but only because retirees are less likely to live near military hospitals and clinics. They pay less on average because they already use fewer military medical services.

COLLECTING FROM PRIVATE INSURANCE COMPANIES

Every year military hospitals admit over a half million military retirees and dependents, and military clinics treat over 27 million outpatient visits by such beneficiaries. Surveys show that about 16 percent of these patients have private health insurance, usually obtained through a civilian employer or union. Their policies typically pay for 80 percent of covered expenses above some deductible, often $100--but do not pay expenses incurred under the military medical program.

Thus DoD may spend about $375 million this year to treat inpatients and outpatients who have private insurance coverage. DoD would be able to recover 60 percent of such spending, for a total savings over the next five years of $1,415 million, if it billed the private insurers. New administrative costs would offset part of these savings. DoD has recommended legislation to realize savings from insurance collections.

Legislation Needed

To collect from private health insurers, the Congress would need to pass legislation preventing insurers from excluding the federal government from reimbursement, since they usually include this restriction in their basic contracts. As a precedent, DoD now collects costs from insurers when a policyholder negligently injures a military beneficiary.

The estimated savings from such collections are based on the assumption that the Congress would require insurance companies to cover average costs. DoD does not know what its hospitals and clinics spend on care for each patient with private insurance, because its cost accounting system only identifies average costs. But DoD estimates that it spends an average of $391 for each day an inpatient stays in a military hospital: $327 on the direct costs of operations and maintenance, the rest on the indirect costs of depreciation, administration, and retirement pay. Outpatient visits cost $49 on average, of which $36 covers direct expenses. Insurers might object to covering average costs that are not directly related to specific charges. But, again, there is precedent for this since DoD now collects average costs in negligence cases.

Effects of Collecting

Insurers would probably raise rates for all their policyholders, though the increases nationwide should be modest. They would not as a rule be able to single out their military policyholders and charge them higher premiums, because most military retirees and dependents with coverage belong to plans that include many other civilians.

BROADER APPROACHES TO REFORMING MILITARY HEALTH CARE

If insurers were required to reimburse DoD for military medical services, they might fear more rapid increases in their costs in the future because they have no oversight of military hospital and clinic costs. DoD could meet this problem by embracing broader reforms of the military medical program, such as prospective reimbursement and closed enrollment. These reforms might also save even more of DoD's medical dollars, both in military hospitals and in the Civilian Health and Maintenance Program of the Uniformed Services (CHAMPUS).

Linking CHAMPUS and Medicare

This year the national Medicare program for the elderly began to set payments in advance, according to Diagnostic Related Groups (DRGs). DRGs place patients into 467 categories, defined by costs of treatment and clinical characteristics. Hospitals will have strong incentive to hold down costs under prospective reimbursement, since if they keep expenses below the set payments they will keep the difference, while if costs exceed the payments they must absorb the loss.

The Congress has already authorized CHAMPUS to use Medicare's reimbursement schedule, including prospective reimbursement. But to carry out this new method the Congress must also require hospitals participating in Medicare to participate in CHAMPUS, which means amending the Social Security Act.

Linkage with Medicare would allow CHAMPUS to benefit from Medicare's lower payment schedule and from any further savings realized because of prospective reimbursement. Linkage would also prevent hospitals from shifting costs to CHAMPUS patients to offset lower payments from Medicare. The result should be immediate savings for CHAMPUS of $100 million a year, with further savings possible in the future. To guard against potential problems, CHAMPUS might observe Medicare's experience before fully embarking on a new system.

Prospective Reimbursement in Military Hospitals

DoD might also be able to use the DRG method to set in advance the amounts military hospitals spend for each patient. DRGs have the advantage of linking costs with specific medical outputs, which could improve budgeting and make the delivery of services in military hospitals more efficient. This offers the promise of large potential savings. First, though, DoD would need to define and set payments for its own DRGs and probably would have to provide more authority to local hospital commanders.

Closing Enrollments

Along with prospective reimbursement, "closing enrollments" could also improve budgeting. Under closed enrollment, also called "health enrollment," DoD would assign some of its beneficiaries in a specified geographic area to a military hospital, and others to civilian sources of care (such as Health Maintenance Organizations); they would not be allowed to shift from one source to another. Closing enrollments would, for the first time, give military medical managers a clearly defined population base to use for their planning and in that way might substantially improve their efficiency. DoL has only begun to study the feasibility of this, and the problems of closing the enrollment of a highly transient military population remain to be answered.

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CHAPTER I. THE MILITARY HEALTH CARE SYSTEM

The Department of Defense (DoD) now spends over $5 billion a year on medical services. About $4 billion of this spending covers almost all the costs of caring for patients in military hospitals and clinics; together these hospitals and clinics make up the "direct" part of the military health care system. Patients receiving direct care pay only a small part of the costs. The remaining $1 billion in yearly spending pays for civilian medical services supplementing direct care, under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Military hospitals and clinics supply full medical services to the 2.1 million men and women on active duty in the armed services, and to the roughly 1 million military personnel in the reserves when they are on active duty. When space is available, military facilities also offer inexpensive care to over 7 million people who are not on active duty. These beneficiaries include about 2.6 million dependents of active-duty military personnel and 4.5 million military retirees and their dependents and survivors.

The cost to DoD of supplying dependents and retirees with inexpensive medical care, as well as concern over the timeliness of service, has prompted many suggestions for reforming the military health care system. One widely discussed approach would charge those who are not on active duty fees for their outpatient visits to military hospitals and clinics. That such visits are free may encourage too heavy a use of outpatient medical services. Such fees would not only raise revenue but also cut down on the long waiting lines that burden many military medical facilities and possibly reduce spending for CHAMPUS. Chapter II analyzes the effects of charging for outpatient care.

Another approach to reducing spending would change the law so that DoD could collect from private health insurance companies when their policyholders receive direct care. Private insurers cover many patients in military hospitals and clinics, but generally do not reimburse the government for its medical services. Chapter III discusses the effects of collecting from private insurers.

Both proposals are quite specific and could clearly save money. But critics of military health care have also called for broader approaches to holding down costs and improving service. These approaches, discussed in Chapter IV, are more difficult to assess but could conceivably save large sums.

The rest of this chapter discusses the military health care system in greater detail.

DIRECT CARE

The direct part of the military health care system includes more than 160 hospitals and 300 clinics, supported by over 150,000 military and civilian personnel. Active-duty personnel receive almost all their care from the direct part of the system. But patients who are not on active duty account for 70 percent of outpatient (ambulatory) visits to military physicians, and 60 percent of days spent in military hospitals. Table 1 shows in more detail how the use of direct medical services is distributed among the different categories of beneficiaries. Among those not on active duty, dependents of active-duty personnel use the most services. Though they make up just 34 percent of all those beneficiaries not on active duty, they account for 57 percent of nonactive-duty outpatient visits.

Patients receiving direct care pay very little. Outpatient visits cost nothing. A hospital stay costs dependents $6.80 a day, retired officers $3.70 a day, and retired enlistees nothing.

Inexpensive care does, however, exact a price in time. Patients not on active duty may wait a long time for care. In 1981, for example, they had to wait 14 to 28 days for routine appointments with Army physicians. One reason for long waits is that the military gives first priority to treating active-duty personnel. Dependents of active-duty personnel rank second in priority; members of the senior Reserve Officer Training Corps (college students preparing to be officers) third; and military retirees and their dependents and survivors, fourth. Because of the long waiting lines, nonactive-duty patients (particularly retirees and their dependents) may often turn to civilian providers of outpatient care. Thus the direct part of military health care cannot accommodate all the eligible outpatients, at least on a timely basis.

CHAMPUS

When military beneficiaries cannot get the medical care they need in the nearest military facility, they can use the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This program partially reimburses the costs of services received from civilian providers of health care. People living far from military facilities, roughly 40 miles or more, can routinely use CHAMPUS. People who live within 40 miles of a military medical facility, inside so-called "catchment areas," must get permission from their local military medical commander to use CHAMPUS for hospital care. (Permission comes in the form of a "nonavailability statement" issued

TABLE 1. DIRECT MEDICAL SERVICES: DISTRIBUTION OF BENEFICIARIES, AMBULATORY VISITS, AND HOSPITAL DAYS IN THE CONTINENTAL UNITED STATES BY CATEGORY OF BENEFICIARY, FISCAL YEAR 1984 (In percent, totals in thousands)

Category	Beneficiaries	Beneficiaries in Catchment Areas a/	Ambulatory Visits	Hospital Days
Active-duty personnel	20	24	28	39
Dependents of active-duty personnel b/	27	32	41	27
Enlisted c/		23	31	22
Officer c/		9	10	5
Retirees and their dependents b/	51	42	28	29
Enlisted c/		30	21	20
Officer c/		12	7	9
Survivors b/	2	2	3	5
Enlisted c/		1.5	2	4.5
Officer c/		0.5	1	0.5
Totals	8,340	6,500	38,000	4,770

a. Catchments are defined as the area in a roughly 40-mile radius around a hospital.
b. Distribution among groups from DoD's Resource Analysis and Planning (RAPS) model.
c. Distribution between enlisted and officers within categories from DoD Health Use Survey.

before the patient gets non-emergency care.) But in most catchment areas, residents can still routinely use CHAMPUS for outpatient care.

CHAMPUS costs patients more to use than do military facilities. Outpatients pay all expenses up to $50 for themselves or $100 for their families, and 20 percent of expenses above these limits. Inpatients who are dependents of personnel on active duty pay the greater of $6.80 a day or $25 for their entire stay in the hospital. Retirees and their dependents and survivors pay 25 percent of all expenses. CHAMPUS places no limit on the amount of such cost-sharing, which can become very large in the event of catastrophic illness.

Private Medical Insurance

Despite the supply of direct military and subsidized civilian medical care, many families of active and retired military personnel have private health insurance. More than half the military retirees buy supplementary insurance that protects them against catastrophic illness, because CHAMPUS places no limit on cost-sharing. Many military families also have full medical coverage, often because a family member works for an employer supplying health insurance. Others get insurance through fraternal or social organizations, and some buy coverage on their own.

WHAT MILITARY FAMILIES PAY FOR MEDICAL CARE

Health care comes at modest cost to military families. They incur relatively low direct out-of-pocket expenses, and many do not have to cover the costs of health insurance. Some analysts see this as a reason for changing the military health care system. Table 2 shows that families of active-duty officers spend, on average, only $215 a year for medical care (1984 dollars); families of active-duty enlistees spend only $285. Few of these families purchase health insurance; premiums for insurance amount to only $55 of the average $215 spent by families of active-duty officers for medical care and only $60 by families of enlistees. Thus, direct out-of-pocket expenses account for over three-quarters of average spending. Families of retired personnel spend, on average, much more, particularly for health insurance: families of retired officers spend $1,120 a year for medical care, of which $410 is for insurance; families of retired enlistees spend $835 for medical care, of which $305 is for insurance. 1/

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1. These assume patterns of use from 1978. Today's actual expenses may be lower if more people use the direct system.

TABLE 2. AVERAGE SPENDING ON MEDICAL CARE BY FAMILIES OF ACTIVE AND RETIRED MILITARY PERSONNEL AND HYPOTHETICAL URBAN FAMILIES OF FOUR (In 1984 dollars)

	Average Out-of-Pocket Expenses a/	Private Health Insurance		Total Average Spending	Annual Budget for Urban Family of Four with Comparable Incomes
		Percent Covered	Average Premium a/		
Active-duty					
Enlisted	225	13	480	285	1,865 b/
Officer	160	13	430	215	1,955 c/
Retired					
Enlisted	530	52	590	835	1,875 d/
Officer	720	67	610	1,120	1,955 c/
Survivors					
Enlisted	260	39	275	365	1,865 b/
Officer	175	62	375	410	1,865 b/

a. Figures were originally reported in 1978 dollars. Prices of medical services rose 64.4 percent between 1978 and 1983 and are projected to increase another 7.4 percent by 1984. Accordingly, CBO multiplied reported figures by 1.77.

b. Lower-income living standard according to Bureau of Labor Statistics: $17,050 in 1984 dollars.

c. Higher-income living standard of $42,350.

d. Intermediate-income living standard of $28,270.

The Importance of Location

Among families headed by active-duty personnel, those living outside catchment areas (roughly 40 miles away from military medical facilities) pay more for medical care than those living inside catchment areas. These families, who usually rely on CHAMPUS and so pay deductibles and coinsurance, report spending $405 a year; families living inside catchment areas report spending an average of $260. Charging outpatients in military clinics could narrow this difference in spending, though only about 4 percent of active-duty families actually live outside catchments.

The disparity by location is greater for families headed by a surviving spouse of a military retiree, of whom 35 percent live more than 40 miles from military facilities. They report spending an average of $630 a year. In contrast, families living closer report spending $320, again probably because military facilities are cheaper than CHAMPUS.

But location does not seem to make as big a difference in the average spending of families headed by retired military personnel. Such families living far from military facilities report spending only $20 a year more than those living closer. Much depends on whether the retiree is disabled. Families headed by disabled retirees report spending about $1,350 more a year than do those headed by able retirees. And disabled retirees who live more than 40 miles from a military hospital report several hundred dollars more in yearly expenses than do disabled retirees who live closer.

Military Compared with Civilian Families

Families served by the military health care system spend less on medical care than do typical civilian families. Table 2 shows that the average family of an active-duty enlistee--whose income places it, by the Bureau of Labor Statistics' (BLS) measure, in the "lower" standard of living category--spends $1,610 a year less than does a hypothetical urban family of four in the "lower" standard category. The average family of a retired officer spends $870 less a year than does its hypothetical civilian counterpart. To estimate these hypothetical family budgets for three standards of living (lower, intermediate, and higher), the BLS assumes membership in a group hospital and surgical plan, a specified number of visits to physicians, eye and dental care, and prescriptions.

That military families spend less on medical care does not in itself mean military health care is overgenerous. Active-duty personnel get free care because the military needs high standards of health to be ready for war. And the military needs some of its extensive health care system as a

base for expanding facilities quickly in the event of war. Still, the large differences in spending between military and civilian families have underlain some of the calls for reforming military health care, including the changes discussed in Chapters II and III.

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CHAPTER II. CHARGING FOR OUTPATIENT CARE AT MILITARY FACILITIES

Should military families be required to pay more of the costs of medical services in the direct care system? The Defense Resources Management Study in 1979, known as the Rice Commission, thought so and recommended charging $3 (roughly $4.50 in 1985 dollars) for each outpatient visit. Such visits are now free. More recently, the President's Private Sector Survey on Cost Control (better known as the Grace Commission) recommended charging $10. And both the Senate and House Appropriations Committees have shown interest in charging outpatients, the former directing the DoD to study the feasibility of outpatient charges and the latter recommending that the Secretary of Defense impose a "uniform minimal charge." Such a charge could not only raise revenue, but also help reduce waiting lines for military health care.

This chapter looks at four alternative ways of charging outpatients. They would apply only to dependents and retirees, exempting those on active duty because the military needs full health care to support readiness for war. Also, they would apply only to outpatients in the continental United States (CONUS). Many feel that military health care overseas now lags in quality behind the direct care available in the United States, one reason being that facilities overseas face delays in getting equipment and supplies; thus, exempting families outside CONUS from outpatient charges could be viewed as compensation for their overseas service. CBO did not look in detail at the effects outpatient charges would have on overseas families because DoD lacks detailed data on the use of medical services overseas.

The four options follow:

- Charge all covered outpatients $5 a visit (similar to the Rice Commission's proposal);
- Charge all covered outpatients $10 a visit, but limit charges to no more than $100 yearly for each person (similar to the Grace Commission's proposal);
- Charge dependents of personnel on active duty $5 a visit and retirees and their dependents and survivors $10 a visit (to mirror the priority given each group in the direct care system); and
- Charge dependents of enlistees and retired enlistees $5 a visit, dependents of officers and retired officers $10 a visit; limit

charges to no more than $100 a year for each member of an enlisted household and $200 for each member of an officer household (to reflect differences in families' ability to pay).

SAVINGS FROM CHARGING OUTPATIENTS

Each of the four options would raise at least $100 million a year from the outpatient fees, though administrative costs to collect the fees would offset a small part of the revenue. And each option could realize still larger savings--to the benefit of both the government and its many military beneficiaries--by cutting down on current use of outpatient services (see Table 3).

All four options would reduce waiting lines for outpatient services in military medical facilities, and so could make possible less recourse to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Today, the direct part of the military health care system cannot always accommodate all the outpatients eligible for care, at least not on a timely basis. Long waiting lines cause some dependents and retirees to turn to CHAMPUS, even though civilian care generally costs them, and the government, more than would direct care.

One reason for long waiting lines in military facilities is that free care leads to increased use of outpatient services. The experience of civilian health plans shows that when their members had to share the costs of visits they visited physicians less often--with no strong evidence of sacrifice to their health. 1/ To the extent that outpatient charges would cut down on visits to military physicians, they would reduce waiting lines, and help save beneficiaries and the government the higher costs of alternative care under CHAMPUS. Those who continued to use military services should also benefit from reduced waiting lines.

CBO based its estimates on several sources: a model that the Office of the Assistant Secretary of Defense for Health Affairs uses to forecast needs for medical services, a survey by DoD on how families used medical services in 1978, and various studies on how outpatient charges affect the use of medical care. Appendix A explains in greater detail the methods CBO used.

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1. Specifically, CBO looked at a California health plan that began to charge in the mid-1960s for previously free care, and at the various health insurance plans in a recent experiment conducted by the RAND Corporation. Appendix A discusses these experiences.

TABLE 3. ESTIMATED SAVINGS FROM CHARGING OUTPATIENTS IN MILITARY MEDICAL FACILITIES IN THE UNITED STATES
(In millions of current dollars)

Option		1985	1986	1987	1988	1989	Total 1985-1989
I.	Charge all $5						
	Revenue	100	100	100	100	100	500
	Administration	(15)	(15)	(20)	(20)	(20)	(90)
	Total	85	85	80	80	80	410
	Total plus CHAMPUS savings	160	165	165	175	180	845
II.	Charge all $10, with $100 limit						
	Revenue	165	170	170	170	170	845
	Administration	(20)	(25)	(25)	(25)	(25)	(120)
	Total	145	145	145	145	145	725
	Total plus CHAMPUS savings	225	230	235	245	250	1,185
III.	Charge active-duty $5, retired $10						
	Revenue	130	135	135	140	140	680
	Administration	(15)	(15)	(20)	(20)	(20)	(90)
	Total	115	120	115	120	120	590
	Total plus CHAMPUS savings	200	210	210	220	230	1,070
IV.	Charge enlisted $5, with $100 limit; officers $10, with $200 limit						
	Revenue	115	115	115	120	120	585
	Administration	(20)	(25)	(25)	(25)	(25)	(120)
	Total	95	90	90	95	95	465
	Total plus CHAMPUS savings	170	175	180	190	195	910

To summarize the savings over the next five years:

- Charging all outpatients $5 a visit could save $845 million--$500 million in revenue, less $90 million to collect the charges, plus $435 million in savings from less recourse to CHAMPUS;

- Charging all outpatients $10 a visit, but limiting individuals' expenses to no more than $100, could save $1,185 million--$845 million in revenue, less $120 million in administration, plus $460 million from CHAMPUS;

- Charging outpatients who are dependents of active-duty personnel $5 a visit, and other outpatients $10 a visit, could save $1,070 million--$680 million in revenue, less $90 million in administration, plus $480 million from CHAMPUS; and

- Charging outpatients from families of active-duty and retired enlistees $5 and outpatients from families of active-duty and retired officers $10, but limiting expenses for dependents of active-duty enlistees to no more than $100, could save $910 million--$585 million in revenue, less $120 million in administration, plus an additional $445 million from less recourse to CHAMPUS.

Charging $5. The first option--which the Rice Commission and the House Appropriations Committee have recommended--could reduce visits overall by about 14 percent. Reductions of this sort happened when civilian health plans began to charge for outpatient services. The remaining visits would raise revenue of about $100 million a year. To collect charges, DoD should have to spend an additional $15 million to $20 million a year (thereby doubling today's budget for various automated data processing systems) to modify its present automated record-keeping systems, such as the Defense Enrollment and Eligibility Reporting System (DEERS). The 14 percent decrease in visits would make room in military hospitals and clinics for most of the outpatients getting civilian nonpsychiatric and nonemergency care under CHAMPUS inside medical catchment areas; over the next five years, this could save an additional $435 million. And since adding these CHAMPUS patients would increase medical workloads by less than 14 percent, waiting times for all should decline.

Charging $10 but Limiting Expenses. The second option--which the Grace Commission and the Subcommittee on Defense of the Senate Appropriations Committee have recommended--would reduce visits by about 12 percent, despite charging twice the first option. The remaining visits would produce revenue of about $170 million a year. The $100 limit on expenses

for each person would diminish the charge's effect on use, because visits after the tenth would be free and hence not constrained by cost-sharing. 2/ Few people visit more than ten times a year, but their frequent visits account for roughly one-third of all use. (Without the $100 limit, visits could drop by as much as 24 percent.) To collect the $170 million in revenue, DoD might have to spend more than under the first option because the limit on expenses would complicate record-keeping. Thus CBO assumed yearly offsetting costs of between $20 million and $25 million rather than $15 million. But reductions in outpatients' use of CHAMPUS could add back savings over the next five years of $460 million, and still reduce waiting lines.

Charging Active-Duty Families $5, Retired Families $10. The third alternative--which would link charges for medical services to each group's priority in the direct care system--would reduce visits overall by about 19 percent, thus raising revenue of about $135 million a year. This option should cost DoD the same as the first option to administer, between $15 and $20 million a year. And it could also save an additional $480 million over the next five years because of reductions in CHAMPUS use.

Charging Enlisted Families $5 and Officer Families $10, and Limiting Active-Duty Enlisted Expenses. The fourth alternative--which would link charges for medical services to each group's ability to pay--would reduce visits overall by about 14 percent. The remaining visits would produce revenue of roughly $115 million a year. This alternative should cost the same as the second alternative to administer, between $20 million and $25 million. Additional savings from less use of CHAMPUS could amount to $445 million over the next five years.

Although outpatient fees would reduce crowding and so permit many CHAMPUS users to get less expensive direct care, they would also compel many other military families to spend more out of pocket. This could erode the willingness of military personnel to pursue active-duty careers. There is also a concern that outpatient fees could affect the health of some beneficiaries by discouraging them from seeking care when they truly need it. The rest of this chapter discusses these concerns.

THE EFFECTS ON SPENDING BY MILITARY FAMILIES

Most of the savings from these four options would come from the pockets of military families. To measure each option's effect, CBO estimated how much average yearly spending would be increased for typical

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2. If the $100 limit applied to an entire family, the $10 fee might produce up to 25 percent less revenue.

families of active-duty and retired officers and enlistees. Because some families use much more medical care than others, CBO also looked at the percentage of families who might have to increase their spending by a considerable amount ($100 or $300).

As a guide to the distribution of expenses across families, CBO took the pattern of visits in 1978, the most recent year for which DoD surveyed the use of medical care. Charging for outpatient visits would, of course, reduce the proportion of heavy users; many would cut down their visits and some would stop visiting altogether. But because the rate of visits to military facilities seems to have risen since DoD took its survey, the pattern of visits in 1978 might not greatly overstate the percentage of families who would have high expenses.

Average Family Spending

Table 4 shows how average spending by military families could rise under each option. In no case is the average increase more than $90 a year. When the charge is the same for families headed by active and retired personnel, active-duty families spend more. Those families are much more likely than retired families to live inside catchment areas, and so to use more outpatient services. DoD's survey found that 14 percent of active-duty families did not visit a military physician in a single year, while 43 percent of retired families did not.

Whether the head of household is an active-duty officer or enlistee makes little difference, except under the fourth option. Then enlisted families could expect to spend $40 more a year on average; officer families, $90 more a year. This difference is roughly proportionate to the difference between officers' and enlistees' earnings.

These modest increases in military families' spending would still not cause their health care costs to approach, let alone exceed, spending by typical civilian families. As Chapter I showed, military families spend hundreds of dollars less on average than do their counterparts in the private sector.

Families with Very High Expenses

Despite the modest increases in average spending, a sizable percentage of military families might have to spend more than $100 a year under each of the options. But fewer than 3 percent would ever have to spend more than $300 in a single year. Table 5 shows the percentage of families who would have to spend more than $100 and $300 a year--amounts chosen

TABLE 4. ESTIMATED INCREASES IN AVERAGE YEARLY SPENDING ON MEDICAL CARE BY MILITARY FAMILIES UNDER ALTERNATIVE OUTPATIENT CHARGES (In current dollars)

	Active-Duty		Retired	
	Enlisted	Officer	Enlisted	Officer
Option I. Charge all $5	45	50	30	20
Option II. Charge all $10, with $100 limit	75	80	45	35
Option III. Charge active-duty $5, retired $10	45	50	60	45
Option IV. Charge enlisted $5, with $100 limit; officers $10, with $200 limit	40	90	25	40

NOTE: Includes families living inside and outside military medical catchment areas.

for illustration. At the high end, 3 percent of the families headed by retired enlistees could have to spend over $300 under the third option. At the low end, none of the families headed by retired officers would have to spend over $300 under the first option.

The size of the fee is sometimes more important than the presence or absence of limits in deciding how many families spend over $300. With a $5 charge and no limit (as in the first option) 1 percent of families headed by active-duty enlistees would have to spend over $300. But doubling the charge, even while imposing a limit of $100 a person (as does the second option), doubles the percentage of active-duty enlisteds' families spending over $300. Limits are less effective because they apply to each family member rather than to the family as a whole; many families making heavy use of outpatient services have no one member who is an especially heavy user.

TABLE 5. ESTIMATED PERCENTAGE OF MILITARY FAMILIES WHO WOULD SPEND OVER $100 AND $300 ON MEDICAL CARE IN A SINGLE YEAR UNDER ALTERNATIVE OUTPATIENT CHARGES (In current dollars)

	Over $100				Over $300			
	Active-Duty		Retired		Active-Duty		Retired	
	Enlisted	Officer	Enlisted	Officer	Enlisted	Officer	Enlisted	Officer
Option I. Charge all $5	9.0	10.0	7.0	5.0	1.0	1.5	0.5	0.0
Option II. Charge all $10, with $100 limit	19.0	20.0	8.0	8.0	2.0	1.5	1.0	0.5
Option III. Charge active-duty $5, retired $10	9.0	10.0	18.0	14.5	1.0	1.5	3.0	1.0
Option IV. Charge enlisted $5, with $100 limit; officers $10, with $200 limit	5.0	28.0	3.5	14.5	0.5	1.5	0.5	0.5

Still, individual limits would prevent any person from spending a large sum on medical care.

EFFECTS OF ADDED SPENDING ON RETENTION

Military personnel would probably see outpatient charges as an erosion of their traditional benefits. Coming on top of the decision to hold pay raises in 1983 and 1984 below those in the private sector, charging outpatients might work to the disadvantage of retention, or the willingness of people to stay in the military.

Outpatient charges averaging no more than $90, however, would amount to a small percentage of military salary, seldom exceeding 2 percent. Today military "salaries" (which include basic pay, cash allowance for food and housing, and the tax advantage from getting tax-free allowances) range from roughly $11,000 for a new recruit to more than $65,000 for a senior officer (an O-6 with 30 years of service). While research has shown that reducing benefits decreases the rate of retention, outpatient charges would be too small to have great effect.

Any effect charges might have would not prevent the services from continuing to expand the career forces (those with more than four years of military service). Retention among enlisted personnel is now at an historical high: about 52 percent of enlistees completing their first term of service stayed in the military in 1983; in 1980, a low point for military manpower, 39 percent stayed. CBO projects that by 1989 the number of enlistees with more than four years of service could be 15 percent higher than at the end of 1983, even if civilian unemployment falls to 6.5 percent by that year. Modest cuts in benefits because of outpatient charges should not reverse this trend. And if outpatient charges seriously harmed retention in certain key skills, DoD could target special pays or bonuses to fix the problem at less cost than supplying everyone with free outpatient care.

EFFECT ON HEALTH

Despite the low cost and other advantages of outpatient fees, one key concern remains--their effect on health, especially among families with low incomes. Opponents of outpatient fees fear that they might lead some beneficiaries to put off seeking necessary care, perhaps until their symptoms worsened to the point of requiring hospitalization. But available evidence suggests that this is unlikely, except perhaps at the lowest levels of income.

Evidence on Adults from RAND's Health Insurance Study

A health insurance study by the RAND Corporation--which assigned families to a variety of insurance plans with different degrees of cost-sharing--dispels the fear that paying for outpatient care leads to more hospitalization. RAND found that members of an insurance plan that charged outpatients but paid entirely for hospital care were hospitalized less often than members of plans that supplied care free of charge for both outpatients and inpatients.

To examine the medical consequences of less use, RAND compared the health of members aged 14 to 64 under the different insurance plans. Researchers collected data on general health (such as physical health and health perceptions) and health habits from a medical history questionnaire; medical screening examinations yielded data on blood pressure, cholesterol, and vision. RAND found that the free insurance plans did not improve the average member's health any more than did the cost-sharing plans. 3/ Nor did RAND find differences in this respect among the cost-sharing plans. Moreover, RAND found no significant differences among subgroups of different income or initial health.

Free care did benefit poorer people who had specific conditions such as myopia or hypertension before they joined the experiment (who RAND identified as members of the "high-risk" group). By better controlling blood pressure, the free plan reduced the risk of early death 10 percent among the high-risk poor. But the free plan did not improve the health of better-off members of the high-risk group, whose financial status more closely matched that of most military families.

Evidence on Infants

Evidence on medical care for infants corroborates RAND's findings. Variations in the rate of infant mortality by states, after adjusting for differences in income and schooling, show no correlation with the number of physicians per person. But researchers have found that medical programs aimed at particularly high-risk groups, such as poor women, substantially reduce infant mortality. The quantity and quality of care available may thus be critical for groups at high risk, while for groups with little risk, such

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3. R.H. Brooks, J.P. Newhouse and others, "Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial," New England Journal of Medicine, vol. 309, no. 23 (December 1983).

as well-educated and well-fed mothers, small changes in the quantity and quality of care may be of relatively minor importance. 4/

Cost-Sharing and the Health of Military Beneficiaries

What do these results mean for beneficiaries who would have to pay for outpatient care that is now free? The evidence, though not conclusive, suggests that the health of most nonactive-duty members should be little affected. But charging outpatients $5 or $10 a visit--particularly without limiting expenses--could be detrimental to the health of some poorer members. These would be mainly among the families of junior enlisted personnel on active duty and families headed by elderly spouses who are survivors of military retirees.

To prevent negative effects, the military medical departments could invest some of the savings from the outpatient fees in programs that target high-risk groups, such as screening for hypertension. Such programs could protect the few who would be at risk at far less cost than giving everyone free ambulatory care. 5/ And any program of charges could be modified, if problems arose, to require smaller fees (or even no fee) from the families least able to pay.

SUMMARY

Charging outpatients in military facilities could raise $100 million to $170 million a year in revenue alone. In addition, the charge could reduce heavy use of medical facilities and thereby help to save at least $435 million over the next five years in expenditures for the use of civilian care (CHAMPUS), as well as reduce waiting times for all patients. Average costs to military families would rise modestly, but would not approach those typical of the private sector. Nor should the fees seriously hurt either retention or the quality of health care.

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4. See V.R. Fuchs, Who Shall Live? Health, Economics, and Social Choice (Basic Books, 1974), pp. 36-37..

5. R.H. Brooks, J.P. Newhouse and others, "Does Free Care Improve Adults' Health?", p. 1,433.

While the various options would save similar yearly amounts, they would have different effects on different categories of military families. If the Congress wanted to limit the percentage of families who would pay substantially more out-of-pocket costs, it could choose options that put a limit on expenses, such as the second and fourth options. And if the Congress also wanted groups with higher incomes to assume most of the added out-of-pocket expenses, it could choose options that charge officers more than enlistees, as does the fourth option.

CHAPTER III. COLLECTING COSTS FROM PRIVATE HEALTH INSURERS

Should private insurance companies help pay for the medical care their policyholders receive from the military? Both the Grace Commission and the House Appropriations Committee have taken the position that collecting some of the costs of treating inpatients and outpatients would raise much revenue without hurting military beneficiaries. The Administration has included this proposal as a legislative contingency in its budget for fiscal year 1985 and, anticipating start-up late in the fiscal year, has reduced its budget by $25 million. To collect from private insurers, the Congress must enact legislation compelling them to pay, because most now will not.

Collecting costs would continue a trend of having private insurers pick up a greater share of military medical costs. Recently, the Congress required that CHAMPUS not reimburse beneficiaries who have private coverage until they bill their insurance companies, after which CHAMPUS pays for services that the insurer does not cover.

This chapter estimates the savings, and discusses the pros and cons, of collecting from private insurers for costs in the direct part of the military health care system. As with outpatient charges, active-duty personnel would be excluded. Their care directly supports military preparedness, and so is the exclusive responsibility of the federal government.

SAVINGS FROM COLLECTING

Collecting from private health insurance companies could pay for about 8 percent of the direct system's hospital costs--or $945 million over the next five years--and 4 percent of its outpatient costs--or $470 million through 1989. Table 6 shows estimated savings over the next five years, based on data and methods discussed briefly below and in more detail in Appendix B.

Basis for Savings Estimates

DoD may be spending about $190 million this year on medical care for inpatients who have private coverage. Every year, over half a million patients who are not on active duty enter military hospitals, each staying an average of about five days. A 1978 survey showed that roughly 16 percent of them have private health insurance, including 5 percent of the dependents of persons on active duty and 25 percent of the retirees and their

TABLE 6. ESTIMATED SAVINGS FROM COLLECTING MILITARY MEDICAL COSTS FROM PRIVATE HEALTH INSURERS (In millions of current dollars)

	1985	1986	1987	1988	1989	Total 1985-1989
Inpatient care						
Dependents of active-duty personnel	15	20	20	20	20	95
Retirees and their dependents and survivors	150	155	170	180	195	850
Total	165	175	190	200	215	945
Outpatient care						
Dependents of active-duty personnel	15	15	20	20	20	90
Retirees and their dependents and survivors	65	70	75	80	85	375
Total	80	85	95	100	105	470
Total Collections	245	260	285	300	320	1,410

dependents and survivors. No one knows what the costs of treating this group of patients are, but the average cost of a hospital day for all patients amounts to $391. About $330 of this average cost supports pay for medical personnel, and operation and maintenance ("direct" costs); the rest pays for depreciation, administration, and future retirement pay for medical personnel ("indirect" costs).

DoD may also be spending about $185 million this year to treat outpatients who have private health insurance. Outpatients who are not on active duty make over 26 million visits to military clinics every year. Roughly 20 percent of them also have private coverage. Each of their visits costs DoD an average of $41 in direct expenses, and another $8 in indirect expenses.

To estimate collections, CBO assumed that insurance companies would cover 80 percent of direct and indirect costs above deductibles. Insurers typically require policyholders to pay all medical expenses up to $100, and 20 percent of expenses after that.

Costs of Administration

Table 6 does not reduce savings by the costs of administering collections, but these costs should be modest. DoD would, of course, have to adjust accounting systems (such as the Defense Enrollment and Eligibility Reporting System, DEERS) to record information about insurance coverage. But when CHAMPUS started "second-payer" provisions--meaning that CHAMPUS only reimburses when a beneficiary's other insurance, if any, pays first--the fiscal intermediaries that administer CHAMPUS reported spending little more to process claims. Though collecting for outpatients, in particular, might create administrative problems because of the volume of visits and the relatively low cost of each, the adjustments to administer collections could piggyback on the charges for collecting outpatient fees. Thus, added costs should be modest.

NEED FOR LEGISLATION

DoD would need legislation to collect from insurers, because many insurance companies put exclusionary clauses in their contracts that bar federal agencies from reimbursement. When the Veterans Administration started a similar program of collecting from private insurers, it recovered very little of the costs because of such exclusionary clauses. 1/ The Congress would have to prohibit insurers from excluding the federal government as a potential beneficiary. The legislation could also require insurers to cover the overall average direct and indirect costs of military medical care. This has precedent: DoD now collects average, rather than actual, cost from an insurer when a policyholder negligently injures a military beneficiary. Alternatively, DoD could revise its cost accounting (the Uniform Chart of Accounts) to identify individual patients' actual expenses. Since this would entail major redesign, DoD could in the interim use information from CHAMPUS to set rates for particular diagnoses.

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1. See Office of the Assistant Secretary of Defense for Health Affairs, A Report on the Feasibility of Military Health Care Facilities Coordinating Their Benefits with Those Covered by Third-Party Payers (October 1983), p. 3.

Legislation to end exclusionary clauses may be difficult to enact. The Veterans Administration has tried several times to have the Congress pass similar legislation, without success.

EFFECTS OF COLLECTING FROM PRIVATE INSURERS

If required to pay for military medical care, insurance companies would probably raise their rates for all policyholders. They would not be able to single out military families for higher premiums because most plans that include military retirees and dependents also include many other civilians. Moreover, the average increase in premiums nationwide would be small, since private insurers would have to pay out less than 0.5 percent a year more in benefits.

Large-scale collecting from private insurers could reduce the military's incentives to contain costs. To the extent that DoD collected actual costs (after revising its cost accounting systems), military hospitals might have less incentive to deliver services efficiently, since they could pass on costs to third-party payers. Insured patients make up so small a proportion of patients, however, that the effect on cost incentives might be small.

Collecting military medical costs would also meet opposition from private health insurers. They would dislike paying average charges rather than actual charges, in the event that DoD based collections on average costs. They would also dislike raising premiums to cover the additional costs of military care. Moreover, they would have less control over those costs than they have in civilian hospitals, where some insurers who have felt a responsibility to their policyholders only to pay for "reasonable" costs have been able to place limits. Some Blue Cross plans do this by limiting reimbursements or setting rates in advance for particular services. Some even audit hospital records on costs to look for overuse of medical services.

Reforming military budgeting for health care to include a system of prospective reimbursement--which Medicare is now applying--could prevent these problems. It would both rationalize costing and prevent military hospitals from passing on too many costs to insurers. Chapter IV turns to these broader reforms.

CHAPTER IV. BROADER REFORMS OF THE MILITARY HEALTH CARE SYSTEM

Efforts to reduce the costs of military health care might be more effective if certain broader changes were made in the way the system works. While the changes might be difficult to enact, they hold the promise of savings that go beyond those discussed in the last two chapters, in both the direct and indirect parts of the health care system. This chapter discusses two approaches for broad reform of the entire military health care system: prospective reimbursement and closed enrollment.

PROSPECTIVE REIMBURSEMENT

The Congress recently has given DoD the authority to use Medicare's schedule of hospital reimbursement, including the new method of prospective reimbursement, in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This would make it possible for CHAMPUS to determine in advance the rates at which it would reimburse hospitals for its beneficiaries. Prospective reimbursement would give hospitals incentives to hold down costs, because they could keep the savings if their costs were less than the preassigned payment; if they exceeded the set payment, they would have to absorb the difference. It would also keep hospitals from shifting costs from Medicare patients to CHAMPUS. This approach could save CHAMPUS at least $100 million a year, and perhaps even more in the future.

Linkage with Medicare

Adopting prospective reimbursement in CHAMPUS will not be feasible, however, until the Congress takes a critical second step: amending the Social Security Act to require hospitals and other insitutions participating in Medicare to participate also in CHAMPUS. Since CHAMPUS is responsible for less than 1 percent of community hospitals' revenue, they might turn away CHAMPUS patients, or bill them additional charges, if CHAMPUS tried on its own to set lower payments.

Background on Medicare's New Method of Prospective Reimbursement

To limit increases in hospital costs, Medicare will set in advance the rates at which it will reimburse hospitals for each Diagnostic Related Group

(DRG). DRGs assign patients in categories that cost roughly the same to treat and that make clinical sense to physicians. For example, patients over age 70 who are hospitalized for removal of the gall bladder and related surgical procedures fall into one of the 467 DRGs. Rates will vary with hospitals' location (whether urban or rural, and according to census division) and with prevailing local wages. Medicare will make additional payments to teaching hospitals and for cases with exceptionally long lengths of stay.

Medicare is phasing in prospective reimbursement over three years to minimize disruptions. During this period it will use the DRG method to decide an increasing portion of the payment amount for each case; the rest will be decided by each hospital's own cost base. By 1987 it will use only the DRG method to determine payments, and will stop varying payment with census division. During 1984 and 1985, rates of payment for each DRG will increase no faster than the prices hospitals pay for labor and supplies, plus one percentage point. After 1985 a panel of experts will review the appropriateness of this approach to updating payments and advise the Secretary of Health and Human Services, who will have final say.

Medicare will exclude certain costs and types of care from prospective reimbursement, at least for the next few years. Capital-related costs--which include depreciation, interest, and rent--will continue to be paid according to each hospital's own cost base. These costs now make up about 6 percent of Medicare's payments to hospitals. But the Congress included provisions in the Social Security Act Amendments of 1983 that will make certain modifications in how Medicare reimburses capital costs by 1986. The prospective plan does not affect hospitals specializing in long-term care, rehabilitation, children's care, and psychiatric care.

Advantages of Linking CHAMPUS with Medicare

Linkage with Medicare would allow CHAMPUS to negotiate lower reimbursements to hospitals. At present, CHAMPUS usually negotiates discounts from hospital charges averaging 5 percent, while Medicare--because of its power in the medical marketplace--is able to establish reimbursements that are more than 20 percent below hospital charges. Simply by linking CHAMPUS with Medicare, the Congress could have reduced CHAMPUS outlays for hospital care by about $100 million in 1984.

Moreover, the savings to CHAMPUS would grow in future years as Medicare phases in its prospective reimbursement system; CBO projects that Medicare outlays will be 9 percent lower by 1986 than they would have been under the old system of cost reimbursement.

Reservations About Linkage

Some analysts have expressed reservations about linking CHAMPUS with Medicare's new system of reimbursement, mainly because of the absence of experience with DRGs and consequent uncertainty about their effects on health care. They suggest that some hospitals might respond by admitting fewer Medicare and CHAMPUS patients, particularly those most costly to treat, thus reducing beneficiaries' access to quality care. Other hospitals with large proportions of CHAMPUS or Medicare patients might only be able to reduce costs by reducing quality.

CHAMPUS should be able to minimize problems by observing Medicare's experience before fully starting its own prospective reimbursement. It could also try out prospective reimbursement in one or two test regions before adopting the DRG method nationwide.

If the Congress decides to amend the Social Security Act to permit linking CHAMPUS with Medicare, CHAMPUS and its fiscal intermediaries will need to assemble data for setting prospective payment rates for certain DRGs. To do this, the intermediaries managing CHAMPUS claims, mostly Blue Cross plans, will have to change the way they record data about patients. CHAMPUS would not be able to use the specific DRG payment rates set by Medicare, because it serves a much younger population, who may cost less to treat during a hospital stay than older patients. Also, much of the CHAMPUS workload consists of obstetrical or pediatric cases for which Medicare has no DRGs.

CHAMPUS would also need a continuing system of quality control to monitor recording practices, since prospective reimbursement based on DRGs can be quite sensitive to errors in patient data. Also CHAMPUS would have to guard against the manipulation of DRGs by hospitals seeking to inflate their reimbursements.

PROSPECTIVE REIMBURSEMENT IN THE DIRECT CARE SYSTEM

DoD could also use the DRG method of prospective reimbursement to set in advance the amount that military hospitals spend on each patient. In this way military commanders would know precisely what resources would be available for different clinical services, and private health insurance companies would know how much military hospitals actually spend to treat patients with private coverage. Prospective reimbursement could also be used to improve efficiency if hospital managers who spend less than the prospectively set payment were given leeway to use some of those savings elsewhere.

In contrast, current budgeting bears very little relation to actual output. DoD looks at previous years' costs and workloads (for example, "occupied beddays") to project the needs for medical resources. This way of budgeting encourages hospital administrators to boost their counts of workload.

Starting Prospective Reimbursement

Prospective reimbursement would doubtless complicate budgeting for military hospitals. DoD would first have to define its own DRGs and set budgeted payments for them. This would require refining the cost accounting system (the UCA) to collect data on individual patients. And changes over time in the costs of different DRGs might require DoD to reestimate rates of payment each year. 1/ DoD would also need a continuing system of quality control to monitor recording practices for errors in the data. Finally, DoD might have to give military hospital commanders more control over the size of their staffs and other resources, perhaps including the right to hire temporary help or institute new methods of treatment. Such authority might go beyond that now allowed hospital commanders.

The case for a system of prospective reimbursement rests on the hope that it would rationalize budgeting and even reduce spending for military medical care. If DoD started to collect from private insurers, prospective reimbursement would offer assurance that military hospitals were not passing on excessive costs.

CLOSED ENROLLMENT

Restricting beneficiaries' sources of medical care could also improve budgeting. DoD would close enrollments by restricting its military beneficiaries in a given area to one of several sources of medical care: a military hospital, CHAMPUS, a Health Maintenance Organization (HMO), or some other private civilian health plan. Closing enrollments would give each military hospital a clearly defined population base for the first time. Planning for future health care needs would become less uncertain because people would not be able to switch from one source to another, as some now do. Such restrictions on members' use of care could also help prevent large, unexpected increases in CHAMPUS costs, like those of recent years.

Closed enrollment might work best if coupled with prospective reimbursement. In military hospitals, prospective reimbursement would tie specific, individual costs to a clearly defined population base, thus further

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1. Office of Technology Assessment, Diagnostic Related Groups and the Medicare Program: Implications for Medical Technology, July 1983.

removing uncertainty from budgeting. It could also help keep down the costs to the government of medical care from alternative civilian sources.

DoD has yet to answer many questions that would be key to carrying out a closed enrollment, because it has only begun to study the concept's feasibility. How many alternative sources of care will there be in any one area? Can DoD assure equal quality of care from each source? Will regional disparities loom large? How will the services "close" a highly transient population, since the military services yearly move several hundred thousand families around the continental United States and between it and overseas bases?

An especially important question is whether beneficiaries will be permitted to choose their source of care or whether DoD will assign them to a provider of its own choosing. Restricting choice could make medical planning less complicated. It would also prevent relatively light users of medical service from disproportionately selecting private sources of care, leaving the military with responsibility for more costly heavy users.

An argument against restricting choice, though, is that it could be unpopular and might be seen as a further erosion of military benefits. Deciding where to assign patients might also be troublesome. A decision to assign to military hospitals patients whose care would contribute most to keeping medical personnel prepared for mobilization might mean assigning most of the older retirees to civilian sources of care. But since older retirees are likely to need more medical services, civilian health plans might be reluctant to participate in such a closed enrollment. To interest civilian plans in participating, DoD might have to divert many of its "good" risks from military hospitals to the private sector.

CONCLUSION

In considering military health care during this year's debate on the budget, the Congress could choose to focus first on the more specific alternatives discussed in Chapters I and II: charging fees to outpatients and collecting costs from private insurers. If these approaches were adopted, they could save more than $2 billion over the next five years. But the Congress might also wish to continue supporting studies by DoD of broader reforms of the military health care system. Two of the more noteworthy reforms are prospective reimbursement and closed enrollment.

APPENDIXES

APPENDIX A. SAVINGS FROM CHARGING OUTPATIENTS

This appendix explains how CBO estimated the savings from charging outpatients in military facilities.

ESTIMATING REVENUE

To estimate revenue--the largest part of the savings from charging outpatients--CBO defined an ambulatory visit, then decided how many fewer visits nonactive-duty beneficiaries would make because of the charges.

Defining Visits

Only some of the 27 to 29 million yearly ambulatory visits projected by DoD would produce revenue. DoD's projections come from a model that uses information from the Uniform Chart of Accounts for Fixed Military Medical Treatment Facilities (UCA) to forecast health care needs. It projects more than 27 million ambulatory visits to military facilities in the continental United States for 1985, rising to 29 million by 1988--the last year forecasted. 1/ (Growth in population, not changes in the rate of use, causes the rise in visits.) Yet the UCA counts as separate visits what an outpatient might think of as separate episodes in one visit. If a patient visits a primary care clinic and two other specialty clinics on the same day, the UCA counts it as three visits. A complete physical examination that requires the patient to visit four different clinics counts as four visits. The UCA also counts as visits advice over the telephone and some physicians' visits to inpatients.

CBO assumed that DoD would not charge outpatients for more than one visit a day, nor for telephone advice or for visits by inpatients.

The UCA separately identifies only ambulatory visits by inpatients, and they make up only 3 percent of the 27 million or so projected visits.

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1. The Military Health Services System Resource Requirements Forecasting Model of the Office of the Assistant Secretary of Defense for Health Affairs.

Otherwise, the UCA does not distinguish between one type of ambulatory visit and another.

To figure the actual number of chargeable visits, CBO looked at data from a 1978 survey of health care use by active and retired families, conducted by the Office of the Assistant Secretary of Defense for Health Affairs. It is the most recent survey of health care use, and the only source on use by different families. Table A-1 compares use reported by nonactive-duty beneficiaries in the survey with use under DoD's health planning model.

TABLE A-1. RATE OF AMBULATORY VISITS FOR EACH ELIGIBLE BENEFICIARY NOT ON ACTIVE DUTY

Category of Beneficiary	Survey	Model	Midpoint
Active-duty Dependents	3.70	6.90	5.3
Enlisted	3.75	7.00	5.4
Officer	3.50	6.50	5.0
Retirees, Dependents, and Survivors	2.10 a/	2.65	2.40
Enlisted	2.15	2.70	2.40
Officer	1.90	2.40	2.15

a. May be on the high side because a disproportionately large share of retirees and dependents in the sample lived in catchment areas.

The survey shows a lower ratio of visits per person than does the model. One reason may be that rates in the continental United States increased between 1978 and 1982, the base year for the model. DoD has more physicians and better facilities now to treat larger workloads than it did in 1978. Yet worldwide figures show no great changes in use, after adjusting for changes in population. Another reason the survey shows fewer visits may be underreporting; respondents may not have accurately remembered all the times their family members visited a military doctor in the previous 12 months.

TABLE A-2. ESTIMATED CHANGE IN THE RATE OF OUTPATIENT VISITS UNDER DIFFERENT CHARGES (In percents)

	$5 Charge	$10 Charge
No Limit on Expenses	-14	-24
$100 Limit on Expenses	-7	-12
$200 Limit on Expenses	-12	-20

The principal reason for the difference, however, is probably differing definitions of a visit. The true number of chargeable visits probably lies somewhere between the survey's rates and the model's rates. CBO used the midpoint to project ambulatory visits for each major group of nonactive-duty users: 5.5 visits for each eligible dependent of personnel on active duty, and 2.3 visits for each eligible retiree and dependent or survivor of a retiree. The adjusted rate of 5.5 visits for active-duty dependents--most of whom live in catchment areas and so primarily use military facilities--is close to the rate for office visits under civilian health plans that offer free care. 2/

How Many Fewer Visits?

Researchers have firmly established that sharing costs reduces use of medical services. But how many fewer visits to military medical facilities will the various options cause?

For answers, CBO looked at a natural experiment that compared the use of free medical services with the use of chargeable services. Table A-2 shows the changes in visits that CBO assumed for each alternative. A controlled experiment by the RAND Corporation corroborates these findings.

Natural Experiment. The natural experiment happened in Palo Alto in 1966 when Stanford University's comprehensive medical care plan (covering half- to full-time employees and their families) began charging 25 percent

2. The rate of office visits under one of RAND's free care plans was 5.4; under Stanford University's health plan before members paid coinsurance, 5.7.

coinsurance for previously free visits to physicians. This coinsurance raised the average price of a visit from $0 in 1966 to $3.60 in 1968, or roughly $10 in today's dollars. 3/ One year after the plan began charging coinsurance, visits overall had dropped 24 percent. A check of the plan four years later showed the same lower use. 4/

The change in use implies an elasticity for ambulatory care of -0.27. That is, a 1 percent increase in the price of a visit would reduce the demand for medical services 0.27 percent. Thus, if the Stanford plan had charged $5 instead of $10 (in today's dollars), visits overall would have declined about 14 percent. 5/

Had the Stanford plan limited expenses by setting a threshold above which visits were free, demand for medical care would have dropped by something less than 24 percent. CBO estimated that if because of a $100 limit on expenses the proportion of members with over 10 visits had stayed the same between 1966 and 1968, visits overall would have dropped 12 percent; if because of a $200 limit the proportion with over 20 visits had stayed the same, visits would have dropped 20 percent. CBO assumed limiting expenses would have similarly affected demand under a $5 charge.

Stanford's experience may be a conservative guide to similar changes in the military medical program. In the Stanford plan, changes in use depended on age, sex, and socioeconomic status. Subscribers from blue-collar families, for instance, cut back their visits more than others. Though the military's nonactive-duty beneficiaries appear similar to Stanford's members in their age and sex, they include far more "blue-collar" workers.

Controlled Experiment. Starting in 1974, the RAND Corporation placed randomly selected families in six sites across the country in different

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3. Phelps and Newhouse, "Effect of Coinsurance: A Multivariate Analysis, Social Security Bulletin no. 35 (July 1972), p. 23.

4. See Scitovsky and Snyder, "Effects of Coinsurance on Use of Physician Services," Social Security Bulletin no. 35 (July 1972), pp. 3-19; and "Coinsurance and the Demand for Physicians' Services: Four Years Later," Social Security Bulletin no. 40 (May 1977), pp. 19-27.

5. Using the Stanford data, Phelps and Newhouse calculated an arc elasticity over the range 0 to 25 percent coinsurance of -0.137. They also showed in other research that elasticity of demand falls with coinsurance. To calculate the change in demand for a hypothetical change in price from $10 to $5, CBO assumed an elasticity twice that of the above arc elasticity.

insurance plans to estimate how various degrees of cost-sharing affect demand for medical care and health. Under some plans members received free care; under others, members paid for 25, 50, or 95 percent of the medical services they used. RAND limited each family's expenses to some fraction of income. It also paid participants enough to make them no worse off than they were under their previous coverage. 6/

RAND found from early results that people paying 25 percent coinsurance--which averaged about $14 a visit in today's dollars--visited physicians about 20 percent fewer times than people getting free care. These results suggest an elasticity for ambulatory care of about -0.20, which is similar to the experience in Palo Alto. Had RAND's participants paid an average of $10 a visit, they would have visited physicians about 14 percent fewer times. Had they paid an average of $5, they would have visited about 9 percent fewer times.

These reductions resemble those hypothesized for the Stanford plan had it also limited out-of-pocket expenses. Though the comparison is imperfect because some of RAND's plans included hospital coinsurance, which would have affected members' out-of-pocket expenses, RAND affirmed that limits dilute the effect of outpatient charges. If a family thinks it possible to spend beyond its limits, it may hesitate less to incur additional expenses as the marginal costs of those expenditures to it near zero. 7/ Also, RAND found that cost-sharing unrelated to income would differentially affect lower-income families.

ESTIMATING SAVINGS FROM FEWER VISITS

Reductions in outpatient visits would enable DoD to supply nonpsychiatric and nonemergency care directly to CHAMPUS outpatients who live near military physicians. Using data from 1982 (the most recent year for which detailed data on use were available), CBO estimated that people who live inside medical catchment areas will make roughly 2 million nonpsychiatric outpatient visits to civilian physicians in 1984--inclusive of visits

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6. See Newhouse and others, Some Interim Results from a Controlled Trial of Cost Sharing in Health Insurance, RAND Report R-2847-HHS (January 1982).

7. Ferber and Hirsch, Social Experimentation and Public Policy (Cambridge University Press, 1982), pp. 140-41.

patients pay for in full to meet deductibles--at a cost to DoD of more than $95 million. CBO assumed that emergencies would account for 20 percent of these 2 million outpatient visits, roughly the percentage of visits to military physicians in 1978 that were emergencies. Since outpatient fees would cause the forgoing of more than 2.5 million outpatient visits a year in military facilities, the direct care system should be able to absorb all of the CHAMPUS outpatient visits inside catchments, for nonpsychiatric and nonemergency services.

Many CHAMPUS users would probably welcome visiting military physicians if only because they could thus avoid paying the CHAMPUS deductibles. These people would naturally seek direct care as outpatient fees reduced waiting lines among present users. If necessary, however, DoD could make sure that military physicians saw most of the CHAMPUS workload by requiring of outpatients prior permission to use CHAMPUS, as it now requires of inpatients. Alternatively, DoD could raise the CHAMPUS deductible for those inside catchments.

Marginal Savings

Each visit shifted from CHAMPUS to military medical facilities could save DoD at least $36 (in 1985 dollars): each CHAMPUS visit costs the government, on average, about $46, while treating each new outpatient directly would cost about $10. In addition, most of the visits shifted from CHAMPUS would produce revenue from the outpatient fee.

CBO assumed that each added visit would cost DoD 20 percent of the average cost for current visits, even though each visit shifted from CHAMPUS would substitute for one forgone by a present user. The reason is that CHAMPUS outpatients may require a different mix of specialists and therapeutic services from patients now using military physicians. DoD may thus have to spend more money to adequately accommodate CHAMPUS patients. Because of uncertainty about the substitutability of different visits, CBO used a conservative ratio of marginal cost to average cost; in an earlier review of medical economics, DoD concluded that a ratio of 0.20 lies at the bottom of the relevant range for relatively small shifts in demand for medical care. 8/

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8. Department of Defense and others, Report on the Military Health Care Study, Supplement: Detailed Findings (December 1975), pp. 835-36.

ESTIMATING ADMINISTRATIVE COSTS

Over the past few years, the DoD has increasingly automated the administration of military hospitals and clinics, so much so that the Office of the Assistant Secretary of Defense for Health Affairs has concluded that the services could adjust today's automated information systems to collect fees for service. Moreover, the adjusted system would not have to deal in cash. 9/ It could, for example, deduct expenses directly from active-duty payrolls and retired annuities. Or it could send out periodic statements, much as do many health providers in the private sector.

One such system, which DoD installed in the continental United States last year, is the Defense Enrollment and Eligibility Requirements System (DEERS). Everyone in the military community is included in DEERS. Whenever a military member goes to a military or Public Health Service hospital or clinic, the military can immediately check eligibility for service. CHAMPUS will also be able to plug into DEERS.

Automation is also becoming an important part of diagnosis and treatment. The Army, for example, uses the Tri-Service Medical Information System (TRIMIS)--which records information about specified functional areas--in at least 18 hospitals.

Systems such as DEERS and TRIMIS are not now designed to collect ambulatory charges. Because of uncertainty about the exact type of change required, CBO assumed that administrative costs for each alternative would roughly double the present OASD budget for automated data support of DEERS from $16 million to more than $30 million. This assumption may prove to be on the high side, because the Rice Commission assumed that administering a uniform $3 charge would cost roughly $9 million a year (in fiscal year 1984 dollars)--before DoD even had systems like DEERS and TRIMIS. 10/

The estimated savings in Chapter II do not include higher CHAMPUS costs or increased pays to maintain retention, because neither of these costs seems likely.

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9. Office of Assistant Secretary of Defense for Health Affairs, An Analysis of the Feasibility of Imposing a Charge for Outpatient Clinic Visits in Military Medical Facilities (June 1983), pp. 5-6.

10. Donald Rice, Defense Resource Management Study, prepared for the Secretary of Defense (February 1979), p. 102.

CHAMPUS Costs

The deductible of $100 would probably prevent most families from switching to CHAMPUS when one of their members needs to visit a physician--their choice would be between a $5 or $10 charge or the full cost of an office visit (the median charge for which is $25 to $35, not including the costs of drugs or ancillary services). Families anticipating very heavy expenses might also resist switching to CHAMPUS because of that program's unlimited cost-sharing. And if switching to CHAMPUS became a problem, or if too few CHAMPUS users returned to military facilities, DoD could, as noted above, raise the CHAMPUS deductible for families living in catchment areas, or require prior permission to use CHAMPUS for most types of outpatient care.

APPENDIX B. SAVINGS FROM COLLECTING FROM PRIVATE INSURERS

This appendix discusses how CBO estimated the savings from collecting from private insurers.

Estimating the revenue from collecting required answering three questions:

- How many nonactive-duty patients have private insurance?
- How much does DoD spend to treat these covered patients? and
- What share of these expenses will insurance companies pay?

As in Chapter II, CBO used data from the 1978 survey of health use and from DoD's health planning model.

How Many Nonactive-Duty Patients Have Coverage?

A relatively small proportion of patients not on active duty have private insurance. In 1978 private policies covered only 5 percent of the ambulatory visits and 4 percent of the days spent in hospitals by dependents of active-duty personnel; private policies covered 27 percent of the visits and 27 percent of the days spent in hospitals by retirees and their dependents or survivors. Heavy users were no more likely than lighter users to have coverage.

These rates of coverage may overstate potential collections. Some people with health insurance turn to military hospitals and clinics only when they have already exhausted their private benefits. (Unfortunately, no data are available to examine this problem.) Also, the rise in unemployment since 1978 may have reduced the number of families with coverage received through a civilian employer.

How Much Does DoD Spend on Covered Beneficiaries?

DoD does not know what military hospitals or clinics spend on nonactive-duty patients. The UCA--which records costs of operations and

maintenance--does not break expenses down by the status of patients. Nor does the UCA track the expenses of individual patients. It only reports average costs for all patients.

The UCA reports that (in 1984 dollars) hospitals spend an average of $327 a bedday; clinics, $41 a visit. These costs include all the expenses of operating and maintaining facilities, military and civilian salaries, depreciation of equipment, and various support services. Costs to cover depreciation of fixed assets, overall administration, and future retirement pay of today's military and civilian medical personnel add another $64 to beddays and $8 to visits.

The UCA does report how nonactive-duty inpatients are distributed among the various clinical services, such as medical and surgical. Because of differences between active and nonactive patients in the mix of services, inpatients not on active duty appear to cost about 4 percent more on average. But this begs the question whether, for any particular clinical service, military hospitals spend more on one type of patient than on another. If nonactive-duty patients tend to receive more expensive diagnostic and therapeutic services than active-duty patients because of differences in age, then an average cost might understate the potential collections.

What Share of Costs Will Insurance Companies Pay?

A survey by the Bureau of Labor Statistics, together with data from the National Medical Expenditures Survey, show that insurers pay on average 80 percent of their insureds' covered expenses above some deductible, usually $100. (Policies often do not cover some outpatient services, such as dental care.) CBO assumed that, mainly because of the deductible, insurers would pay 40 percent of expenses for outpatients. CBO disregarded the deductible for hospital care on the assumption that most inpatients would meet their deductible through outpatient visits.

CBO assumed that covered expenses would include the average direct and indirect costs of medical care. In the civilian sector most commercial insurers reimburse whatever the hospital charges--they do not dispute the expense because they lack the power in the market to prevail over hospitals. But larger insurers such as Blue Cross negotiate agreements with hospitals under which they pay the costs actually incurred by their beneficiaries (not charges). If the Congress required, they too would have to pay whatever the military hospital charges.

Not all the average costs relate directly to the care of insured nonactive-duty patients. Even if the military treated no nonactive-duty

patients, it still would need many of its personnel and facilities to be ready for war. If the Congress forgave companies some of these average costs --such as the indirect costs of retirement pay, depreciation, and overhead-- collecting could produce much less revenue.